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Sonoma Medicine

The magazine of the Sonoma County Medical Association

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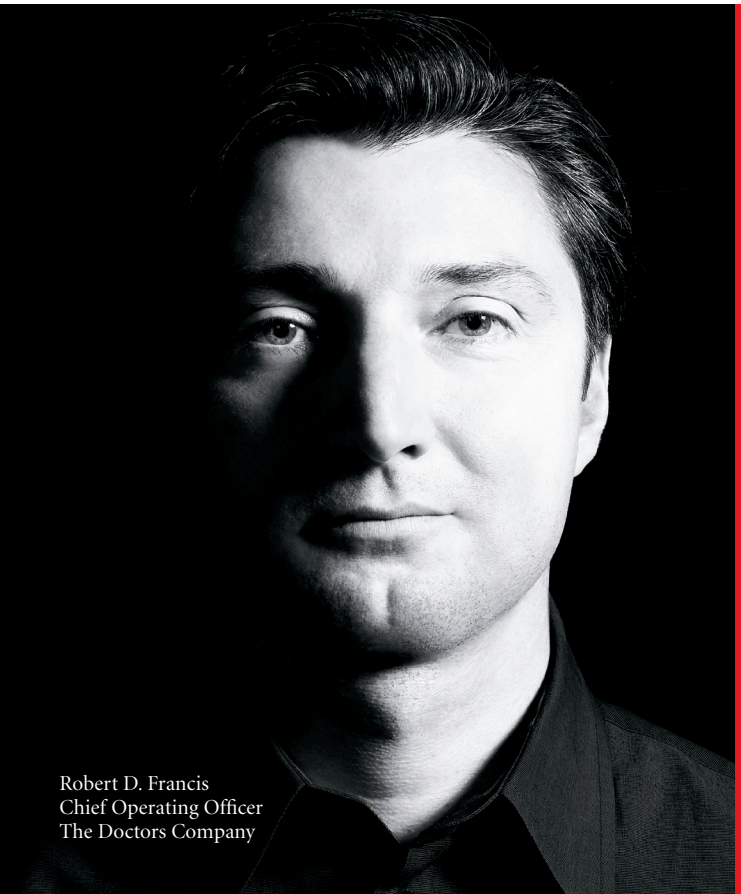

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Volume 63, Number 2 Spring 2012

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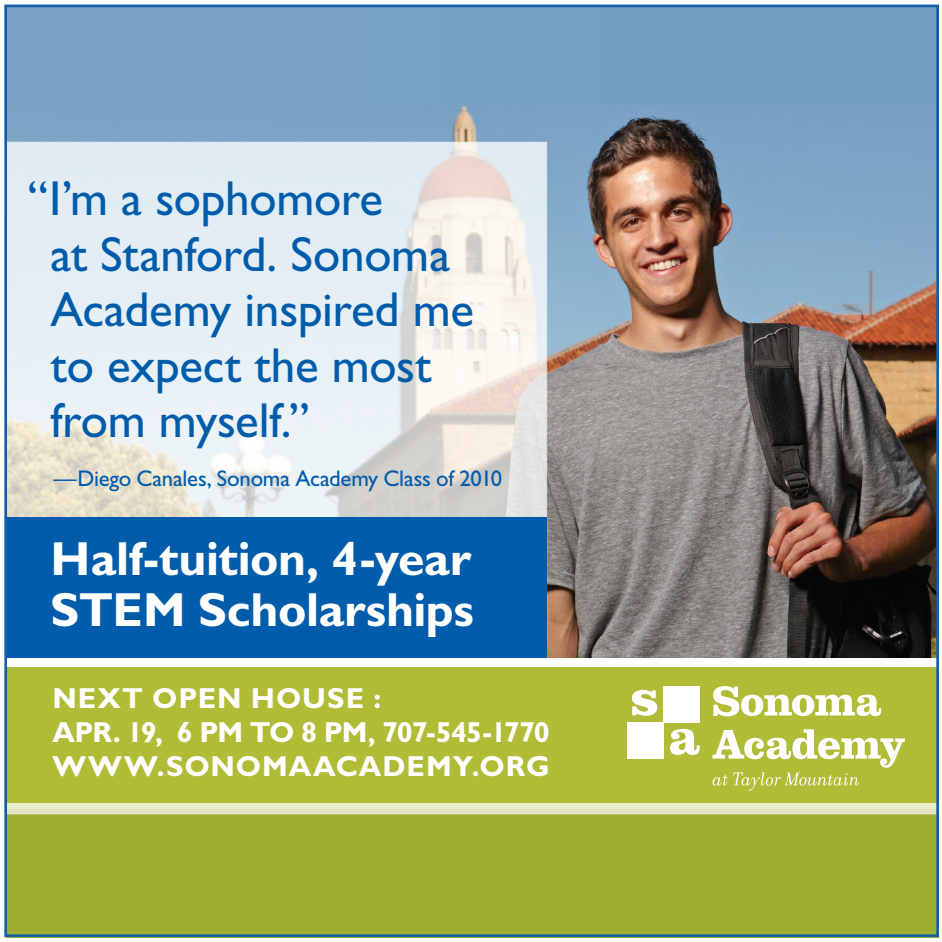
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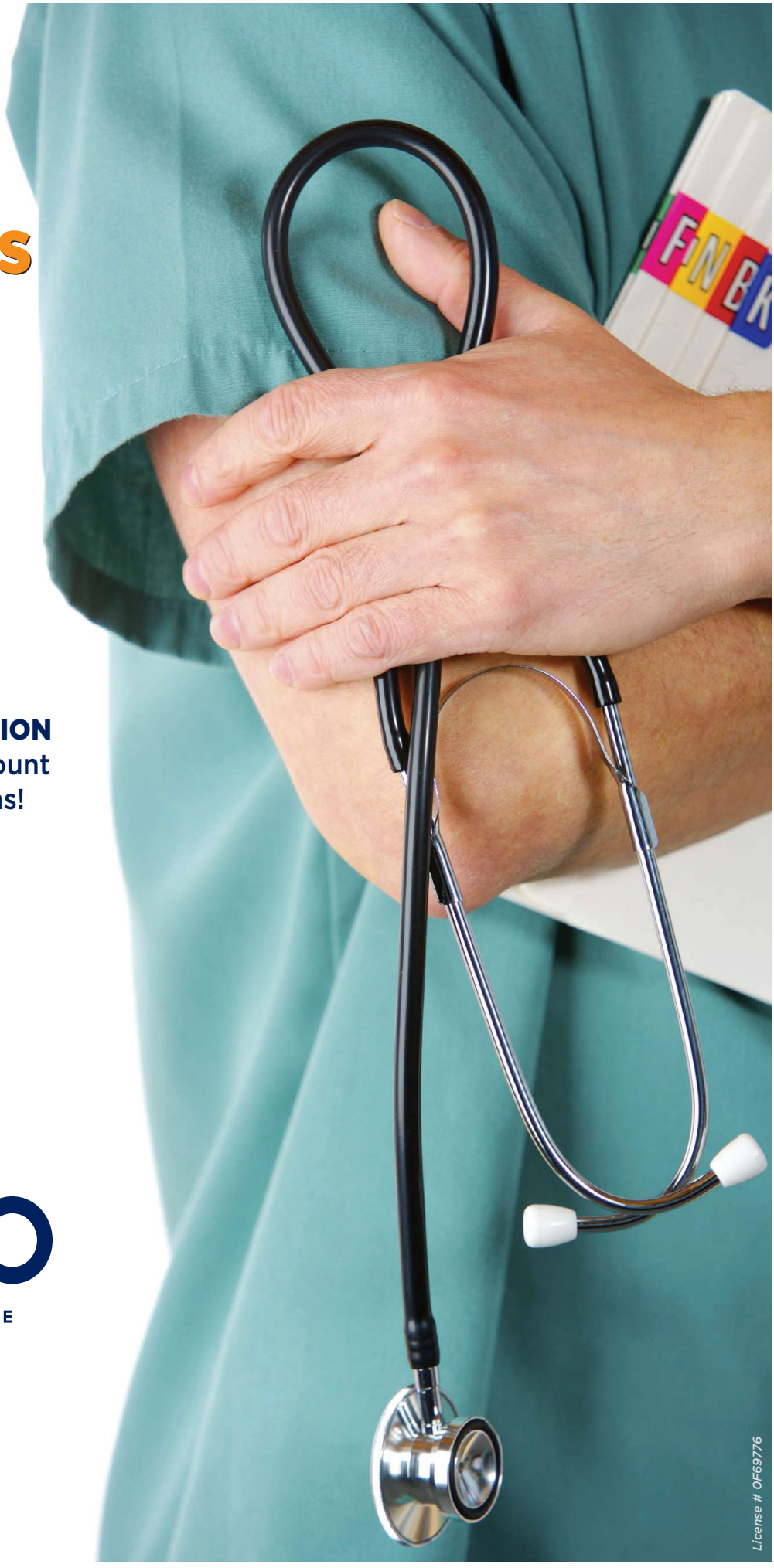

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The Elusive Cookie Jar

Mark Sloan, MD

I was a chubby kid, or as my elderly Aunt Kit described me, "a tad fleshy." A blunt-spoken woman, Aunt Kit's view of humankind and its frailties was shaped by a poor Irish childhood and decades of hard domestic work in swanky high-rises on Chicago's lakefront. Rail-thin herself, she viewed my fleshiness as a worrisome sign of underdeveloped willpower. "Keep the cookies farther than your arm can reach," she sternly advised me, "and you'll not be fleshy long."

Sound advice, though I don't recall ever acting on it. Like a lot of formerly overweight kids, it took me years—and Mr. Dannheiser, a pitiless ex-Marine football coach who ran the fleshiness right off me—to slim down. Willpower had very little to do with it.

Right about the time Mr. Dannheiser was running me ragged, the federal government began turning its attention to health promotion, focusing on improved nutrition, increased exercise, and smoking cessation. We've made significant inroads on smoking—when was the last time you saw someone light up on an airplane?—but those other goals have proven elusive, sometimes depressingly so. A scan of a modern U.S. "obesity map" is sobering: they've had to add new colors (dark red is the latest) as the obesity rate in several states spills over the once unheard-of 35% level.

With the ready availability of junk food, the near-disappearance of physical activity at our teach-to-the-test schools, and limitless electronic inducements to stay firmly planted on the couch, staying fit is even tougher than it was in my childhood. One-third of today's school-aged children are overweight or obese. Given such an unhealthily stacked deck, it's surprising that even more children aren't facing a dismal future of heart disease, hypertension and diabetes.

Dr. Sloan, a Santa Rosa pediatrician, serves on the SCMA Editorial Board.

Finding silver linings in such dark statistical clouds isn't easy, but there are some optimistic trends on the obesity front, both nationwide and locally. Here are just a few:

- Through its iGrow and iWalk programs, Health Action, a county-wide collaboration supported by the Department of Health Services, has helped establish nearly 500 local gardens (a total of 22 acres) and has recruited 84 employers committed to workplace fitness. Another program, Safe Routes to School, promotes biking and walking to school.
- Since 2006, the Healthy Eating, Active Living Community Health Initiative, a project of the Community Activity and Nutrition Coalition of Sonoma County, and funded by Kaiser Permanente, has helped increase physical activity and improve nutrition in the Kawana and Roseland neighborhoods.
- The Redwood Empire Food Bank will provide more than 3,250 tons of fresh produce to the area's needy citizens this year, and its Megan Furth Harvest Pantry delivers fruit and vegetables to 550 families weekly throughout Sonoma County. The REFB also has recently launched a healthy foods program for low-income adults with type 2 diabetes.
- Cotati may soon become the first jurisdiction in Sonoma County to add a Health and Wellness Element to its General Plan. Healthy by Design, a multidisciplinary group of local health, planning, human services and sustainability advocates, continues to promote the connection between land use planning and community health.

These and many other projects seek to address the larger structural issues that contribute to our ever-heavier society. But what can a physician do in his or her own practice, when faced with a daily schedule filled with overweight or obese patients? How can we best set individuals and their families on a path to better health?

This issue of *Sonoma Medicine* is dedicated to those questions. Drs. Cheryl Green and Lynn Mortensen write on the challenges—and rewards—of counseling the individual patient; Dr. Mariah Hansen considers the benefits of the family meal; Drs. Wendy Kohatsu and Rachel Friedman, along with Alisha Prystowsky, describe their innovative nutrition program for women at risk of gestational diabetes; Dr. Tara Scott challenges doctors to become advocates for healthy and sustainable food; and Dr. Jennifer Hubert discusses medical options for obesity treatment. As a postscript, Dr. Deb Donlon reviews *Why We Get Fat: and What to Do About It*, by Gary Taubes, a book that is sure to keep the healthy diet debate raging.

Aunt Kit's advice about my arm and the cookie jar was right on the mark. Willpower will always play a role in staying healthy. But willpower alone, especially in the face of an unhealthy food supply and poorly designed communities, can only go so far. ◇

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Stand Up for Healthy, Sustainable Food

Tara Scott, MD

A few years back, I met "Anne" during an ER shift. She was on her way to being admitted to the hospital with uncontrolled hyperglycemia and cellulitis. Serendipitously, she was able to follow up with me in clinic after her brief stay. The hospital team had started her on insulin, and her sugars were still regularly in the 300s. One day, puzzling over the challenges of her new diagnosis, she said to me, "Doc, I know there's stuff I need to learn about eating right, but I don't know how."

You may be surprised to learn that the next thing I said to Anne was, "Would you consider letting me join you at the supermarket where you shop?" A few weeks later, as we wandered through the aisles of Food Max, I showed her how to read labels. We substituted products she typically bought with similar products that contained more whole grains, less sugar, or shorter ingredient lists—all while trying to stay at the same price point.

By now, you may be rolling your eyes and thinking that my going to the market with every patient who needs to change their diet is not sustainable. You might also be thinking that it's not really part of my job description. You are right on both counts, but I felt completely unprepared by my training to face the incredible rising tide of overweight and diet-related disease. Somewhere amid the Krebs and urea cycles in a biochemistry course in medical school, I was taught about glucose, proteins and fats, and in what percentages they should be eaten and how, if you eat too much, you become overweight. Period.

Dr. Scott is a faculty physician at the Santa Rosa Family Medicine Residency.

If you are like me, this distant set of biochemical reactions never translated into anything useful when trying to educate patients about how to eat. So, I did something radical: I went to the supermarket. When Anne came back to the office a few weeks later, she proudly reported that she had been reading labels. Within six months, she was on a single oral medication and no insulin with a hemoglobin A1c of 6.2, where she remains today.

In the years since I graduated from family medicine residency, a fair amount of journalism has shed light on why I felt confused and ineffective when talking to patients about food. Writers like Marion Nestle and Michael Pollan have exposed how the food industry controls the nutrition advice created by the USDA, the country's main source of information about nutrition.[1,2] Evidence does play a role at times, but it is often obscured by industry concerns. In the 1990s, for example, USDA scientists wanted to say "Eat less meat" because of compelling evidence that a plant-based diet led to better health. The livestock industry subsequently pressured the USDA into changing the message to "Choose food that is lower in saturated fat." This wording wasn't just confusing to the public; doctors got confused too.

Unfortunately, that's not the end of it. The dominant food production systems in the United States constantly employ new chemical and biological inputs that may impact health. Arsenic is just one of many additives that have been pushed by the industry to increase yields, ward off pests and prevent infections caused by overcrowded animals. A 2006 report by the Institute for Agriculture found that arsenic, a known carcinogen, enters the food supply in feed given to factory farmed chickens.[3] Not only do unacceptably high levels of arsenic remain in the chicken, but the chemical is also found on produce grown with manure from chickens who receive the arsenic-enhanced feed.

In the last few years, my colleagues and I at the Santa Rosa Family Medicine Residency have set out to unravel the complexity of food, the food environment and the food system. The role of the physician in mastering this broad new array of topics pertaining to food has yet to be determined. Our belief, though, is that doctors, armed with science and invested with public trust, are actually the perfect people to stand up and become highly visible advocates for healthy food. No matter how much you know about food right now, you can become an agent of change for healthy food.

Below are a few steps that can help you begin advocating for healthy and sustainable food.

Educate yourself. Regardless of when you graduated from medical school, it's likely that you need to learn more about food than you currently know. Being able to make good choices for yourself (and guide patients in making food choices) will mean seeking out lectures, articles and books, and attending conferences on food and nutrition. *The Omnivore's Dilemma* and *Food Politics* are two excellent primers.[1,2]

Be a role model. As you read and learn more, reflect on your personal or family eating and purchasing practices. Do not underestimate your impact as a role model for healthful eating among your family, friends and community. Consider the power of your dollar when you choose where and what kind of food you buy. If you want to see healthy food become more available to everyone, create demand for it by shopping in places that promote the healthiest food with the most positive impact on the community and the least impact on the environment. If you are eating and enjoying a healthy diet, you will also be a more convincing advocate for healthy eating with your patients.

Be an advocate for healthy food in your children's schools, your workplace and your community. If you would like to see frozen fried tater tots taken off your child's lunch menu, your publicly expressed opinion as a doctor may have a powerful impact and could help mobilize other parents with less credibility. If your workplace offers nutrient-poor, calorically dense foods to employees, engage your coworkers in a discussion about how your office, clinic or hospital can support the health of the workers and patients who come there. On a community level, find out when the board of supervisors is discussing topics pertaining to issues like accepting food stamp benefits at your local farmer's market.

Talk to patients about food. Asking patients about what they eat will send them a powerful message that food is important and that you care about what they eat. In this age of hurried office visits and electronic prescribing, it is easy to forget the primary importance that diet plays in most of the chronic conditions we see. Develop a short "review of systems" that allows you to quickly assess a patient's eating habits and identify areas that can be improved. For example, ask "How many sugar-sweetened beverages do you drink in a day?" or "How many days a week do you eat breakfast?" These two simple questions can be easy springboards into talking about healthy eating habits.

Meet patients where they are. Like physicians, patients have varying levels of resources and knowledge about food. While some patients have ample budgets and knowledge, others do not. No matter how great you are at talking about food in simple terms, if you are not aware of your patients' literacy level and economic resources, they may not be able to put your advice into action. One way to get at this is to ask, "How knowledgeable do you feel about what food is healthy? or "Are your food choices limited by your budget?" When you give advice, try to put it into specific terms and talk about foods as whole foods. Use phrases like "Try using olive oil for salads" instead of talking about mono- and polyunsaturated fats. Maintain a set of handouts about food and diet that patients can take away from the visit.

Join an advocacy group. Food advocacy groups can keep you in touch with emerging food issues electronically and give you easy steps to take for action. If you are busy, like most physicians, a simple monthly email or following a Twitter feed is a great way to start getting educated and involved. It's not too late to pressure your representatives for initiatives that promote healthy, local food in the 2012 Farm Bill, scheduled for a vote in Congress later this year.

Be an advocate within your profession. Find out about your professional group's food policies. Encourage your professional group to take a clear stand on policies that impact the way we eat in the United States. If your organization has not yet taken a stand on soda in schools, for instance, put forth a resolution to help the organization take a clearer stand.

As physicians, we may find it difficult to accept that much of what we learned about food and nutrition was not actually science—but the cover has been blown off that secret. Now we are free to dive into the truth about food and to decide how involved we want to be in making change. ◇

Email: ScottT3@sutterhealth.org

For a list of movies, books, articles and advocacy organizations pertaining to food, food systems and human health, visit www.doctorsforfood.info.

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1. Pollan M, *The Omnivore's Dilemma,* Penguin (2006).
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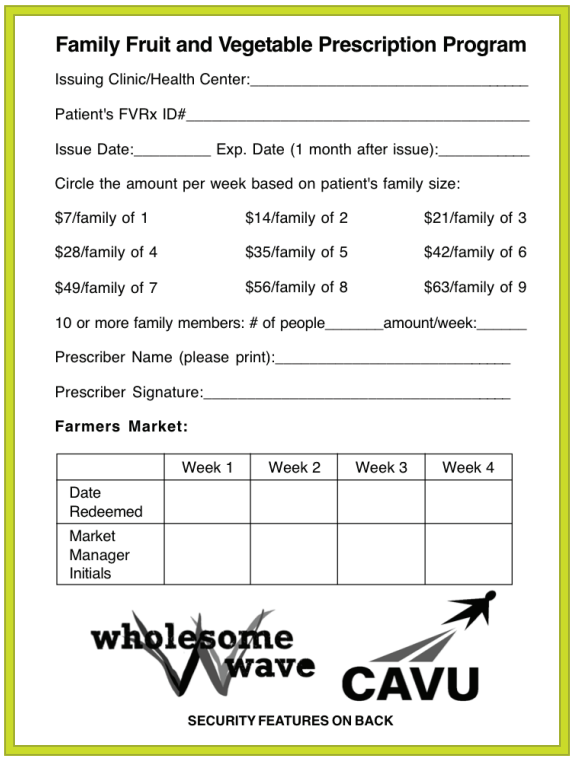
FVRx: Prescribing Fruits and Vegetables for Health

Wendy Kohatsu, MD, Rachel Friedman, MD, and Alisha Prystowsky, BA

Hippocrates admonished physicians to "Let food be thy medicine and medicine be thy food," but how many of us have actually written a *prescription* for healthy food for patients in need? At the Santa Rosa Family Medicine Residency, we are passionate about empowering patients to adopt positive lifestyle changes, and one of the most direct methods to achieve this goal is to increase their access to healthy, fresh food.

We are currently conducting a research trial called FVRx (fruit and vegetable prescription). As part of the study, patients at risk for gestational diabetes mellitus (GDM) receive physician-prescribed vouchers to obtain local vegetables and fruits from the Santa Rosa Farmers Market. The purpose of the study is to determine whether these vouchers, along with intensive nutrition counseling, can help women at risk for GDM consume at least one additional serving of fresh produce per family member per day, maintain healthy weight gain in pregnancy, and reduce the risk of developing GDM.



Family Fruit and Vegetable Prescription Program

Issuing Clinic/Health Center:_____

Patient's FVRx ID#_____

Issue Date:_____ Exp. Date (1 month after issue):_____

Circle the amount per week based on patient's family size:

$7/family of 1	$14/family of 2	$21/family of 3
$28/family of 4	$35/family of 5	$42/family of 6
$49/family of 7	$56/family of 8	$63/family of 9

10 or more family members: # of people_____amount/week:_____

Prescriber Name (please print):_____

Prescriber Signature:_____

Farmers Market:

	Week 1	Week 2	Week 3	Week 4
Date Redeemed				
Market Manager Initials				

wholesome wave CAVU

SECURITY FEATURES ON BACK

Approximately 25-50% of the pregnant women who receive care at the Santa Rosa Community Health Centers are at risk for developing GDM. These women became a natural focus for intervention since they are a cohort with regular clinic visits (approximately monthly), and helping a mother-to-be at risk for GDM affects not only her heath, but also delivery outcomes, fetal well-being and ultimately the health of her entire family.

First-line treatment for women at risk for GDM consists of glucose control through diet modification and exercise. Unfortunately, the highest rates of GDM are concentrated in underserved, low-income communities where families often lack access to fresh fruits and vegetables. Vouchers for the farmers market could address this lack of access.

One of the goals of the FVRx study is to determine whether vouchers can help increase consumption of fresh produce, but we are also looking at the variety of vegetables and fruits consumed. Are families diversifying the greens on their plate, or just eating potatoes every week? We are also collecting secondary outcome measures, including weight gain, baby birthweight, development of gestational diabetes, and behaviors around buying and eating fresh vegetables and fruits.

The FVRx study is part of a national collaborative sponsored by Wholesome Wave, a private foundation. Wholesome Wave's mission is to improve access and affordability of fresh, healthy, locally grown produce to historically underserved communities.

Study Design

Eligible patients were identified during our OB intake clinic at the Vista Family Health Center (part of Santa Rosa Community Health Centers) and were invited to participate in the

Drs. Kohatsu and Friedman are faculty physicians at the Santa Rosa Family Medicine Residency. Ms. Prystowsky is an AmeriCorps member and research coordinator at the Vista Community Health Center in Santa Rosa.

An FVRx study participant shopping at the Santa Rosa Farmers Market.

study. Subjects were then randomized to receive either nutrition education and healthy eating resources (control group), or education and resources, plus farmers market vouchers (intervention).

Recruitment began in September 2011. At each monthly prenatal care visit, both groups of subjects fill out a brief questionnaire regarding fruit and vegetable consumption and receive standardized nutrition education explained by their provider. In addition, the intervention subjects receive an actual paper prescription that is redeemable for fruits and vegetables at the Santa Rosa Farmers Market in the amount of $7 per household family member per week. This equates to $112 worth of fresh produce every month for a family of four. Vouchers continue to be distributed monthly through the duration of the subject's pregnancy.

To date, we have enrolled 60 voucher patients and 43 control patients. We have been thrilled to discover that many of the voucher patients have been coming to the farmers market and bringing their families, some for the very first time. Many have commented to their physicians and the farmers that the food purchased through the FVRx program tastes better and is fresher.

Why the farmers market?

We believe that local, fresh food is not just tastier, but also healthier because nutrients have not been degraded or processed out. We also believe in supporting our farmers, reducing our carbon footprint by purchasing food grown nearby, and boosting the local economy. Only 19 cents of every food dollar spent in America goes directly to farmers. By supporting farmers directly at the farmers market, 73 cents of that same food dollar goes back to them. At the market, our patients are exposed to a wide variety of seasonal crops, and they enjoy the social interaction with the farmers and learning where their food comes from.

In a separate but related outreach program, our team works in partnership with the Sonoma County Department of Economic Assistance, the Santa Rosa Farmers Market and other community organizations to promote the use of EBT (electronic benefits transfer) "food stamps" at farmers markets in Sonoma County. Over the last 10 months, more than $15,000 EBT dollars have been spent at the Santa Rosa Farmers Market.

Early feedback

The FVRx study is still underway, but we have already received positive feedback from several participants. One of our first patients says that she loves the program and that she tells other women to use the farmers market. She feels the vouchers are easy to use and gets most of her fruits and vegetables from the market. She has gone to the farmers market at least twice a month since starting the program in October 2011.

Other patients have commented that

the voucher money has been substantial enough to help them buy fruits and vegetables at the market for their families. Some have said that they have used the money to try new vegetables. One patient who was hesitant to try new vegetables said she would be willing to try new ones if she knew how to cook them (cooking classes are forthcoming). Four patients have offered to give tours of the market to other patients who are unsure of how to use the vouchers.

One of the farmers at the market says that women in the program come back weekly to buy fruit from her and that she uses the money to pay rent for her market space. She says the farmers do what they can to give the women a little extra.

Looking ahead

With $1.24 spent annually per American on prevention versus $1,390 to treat diet-related disease, it's time to seriously look at reinvesting our efforts into prevention. Likewise, with the strong association between poor diet and the chronic diseases that plague our country, it's time to seriously treat food as medicine.

It's ironic that we are conducting a randomized trial that hopes to prove that fresh fruits and vegetables are good for you. What has been most gratifying is to be "walking our talk," and actually *prescribing* local fruits and vegetables to some of our most vulnerable patients, along with supporting our farmers and our community. Each dollar invested in a program like FVRx pays forward threefold by nourishing the consumer, boosting local farm revenues, and uplifting the community as a whole. ◇

Email: kohatsw@sutterhealth.org

We would like to acknowledge Alicia Cohen, MD, for helping us to develop and launch the FVRx program in Sonoma County; the Vista Family Health Center; our local Roots of Change branch; the Kaiser Permanente Community Benefit Grant Program; and Wholesome Wave, which funded the study and allowed us to be one of the sites for the FVRx program.

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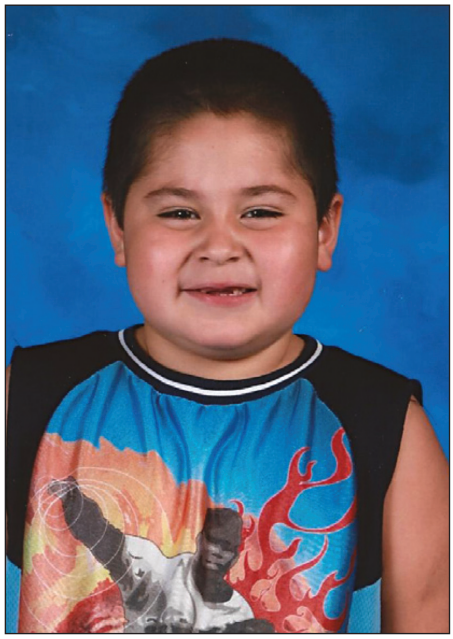
TESTIMONIAL

Hard Truths About Life & Death Choices in My Own Family

Thelma Escobar



This is Angel. He is now 8 years old, and he is a very happy child. Now please look at this picture and imagine that this is your own child, nephew, cousin, niece, grandchild, or a child you know and love. You will do anything to keep this child healthy, safe and happy.

This is my story.

When Angel turned 3 years old, he started to gain weight. I took him to the doctor for his check-up. The doctor told me the weight was not a problem because Angel was growing and he was going to catch up on it and not to worry.

Two years went by. Angel was now 5 years old. He weighed 120 pounds and his weight was going up and up. I changed doctors. This time the doctor paid attention to the weight gain. He suggested we eat more fruits and vegetables in our diet, and he referred me to the weight assessment clinic at the UCSF Benioff Children's Hospital in San Francisco. It took me 2 years from the time of that referral to get my first visit in 2010.

On the day of our first appointment, Angel was not allowed to eat anything before the appointment. We drove to San Francisco. We sat in the waiting room talking and thinking about what the doctor was going to say to us. The clinic staff talked to us about foods that are rich in fiber and how to eat small portions 5 times a day and to eat lots of fruits and vegetables and to drink lots of water. Then we went to the lab, where they did blood tests on Angel. After that we moved to a big gymnasium with many other children, where the staff played games like soccer, basketball, rope jumping, and other games that kept the children moving around, sweating a lot and breathing fast. Staff told us that getting exercise doesn't take more than 20 minutes, two to four times a day and that this was important.

Then we were finally called in to see Dr. Robert Lustig, a pediatric endocrinologist. He asked us about our daily life, what foods did we eat at home, how many times did we eat out, what did we drink. I answered that we eat fruits, vegetables, rice, beans, tortillas; that we drink apple juice and orange juice and that I add water to the juice as recommended by WIC to make it less sweet.

The doctor then asked how many times a week I cook at home and eat out. I said I cook 2 to 3 times a week and I buy fast food 2 to 3 times a week for dinner with soda. On weekends we have family gatherings and we eat cookies and cakes and other foods.

The doctor then looked at me and said, "I have the results of the blood test; your son's pancreas is making too much insulin. This is called *acanthosis.* He is very close to being a type-2 diabetic."

He waited for that information to register in me, then he asked, "Do you want that for him? If you continue feeding Angel as you have done, and allow him to drink juice and sodas and eat fast food and junk food, then he is going to gain more weight and get lots of respiratory infections and get sicker every year."

Then the doctor said, "By the age of 25 or 26, he will be dead."

When I heard his words I was in shock, I did not know what to say.

"If you want to get help from the

Ms. Escobar is a health advisor for Healthier Children, a nonprofit organization in Marin County. She presented this testimonial at the Sonoma County Latino Health Forum last October.

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clinic," he continued, "you must agree to change. If you choose not to make the changes and continue your lifestyle, don't come back."

This was so much to take in, I was absolutely stunned. A thousand thoughts went through my mind at one time. I realized that it was *I* who was going to lose in the end, and regret it for the rest of my life because I did not make the right decision for my child. I recognized that I needed to make a commitment to my child and my family. And I had to remember that if I gave my child a soda I could not come back to the clinic. But the clinic was the only hope we had!

I was determined to give my child a healthy lifestyle. I said to myself, my son means everything to me, he is my world. I made the commitment to my child and to my family to change our lifestyle and the way we eat.

On the way home, my mind was all over, thinking *how? why?* I realized that *I was the one* going to the store and buying the food, bringing it into my home. *I was the one* cooking it and feeding my child. *I was the one* stopping at the restaurants and buying the food. *It was me.* I was the grownup who was not making the right choices . . . because I felt so tired after work, and fast food was too easy.

So I was the one making my child sick. He was my responsibility. He looked up to me, I was his teacher. I cried all the way home, kissing him and hugging him thinking I am not going to lose my child. He is going to live a long and healthy life.

When I got home, I walked in and got the trash can and started to clean my entire kitchen. Then I went to the store and bought fresh fruits and vegetables, water, cereals, bread with fiber . . . and from that point, there has been no soda or juice in our house.

Initially, I felt very much alone fighting with this sickness in my family. I had no one to talk to or to listen to my questions. For the first two months, everything was very hard and always a fight at every meal every day. I was going to bed crying.

One day Angel's school called me in for a meeting. They asked me if my son Angel was eating breakfast at home because he was picking food out of the garbage at school. I could just picture it in my mind—my son eating leftover food from other children. It made me sick, very sick to my stomach. I started to cry, because my son was screaming for help. He did not understand why everything had to change. His own behavior changed, and he did not feel good about himself any more.

I told the staff at the school that Angel was under the care of a weight clinic in San Francisco. I also informed them that he was learning to make good choices when picking out his lunch at school. I asked them to please help him and guide him during lunch time, and support him in changing his habits.

I was working at the North Bay Children's Center when the Garden of Eatin' Project started in 2005. For six years I have been around David Haskell and his beautiful garden, participating in his nutrition education training classes. But I did not take it in. I did not apply it to myself or my family. David and I started to talk, I told him how hard it was to make the changes in the house, and how emotionally and mentally devastated we all felt. We talked about what it was like working with the San Francisco clinic, cleansing our bodies from all the sugar we ate before and trying to build a new healthy lifestyle.

Last year, David offered me a position in his Healthier Children program. I now work with him to help children and especially their families make healthy choices.

I am pleased to be able to share my story with you, the story about my son Angel, and how he is fighting with his weight and how hard it is for him to say no to all the unhealthy foods that are around him. But we are making progress, and I am working with him and the people around him to help him make the life-and-death choices the doctor spoke to us about, the healthy choices for a long life. ◇

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One Patient at a Time

Cheryl Green, MD, and Lynn Mortensen, MD

Not long ago, a 3-year-old boy we'll call John, accompanied by his mother, waddled through the door of Dr. Cheryl Green's office. She thought, "Is this the same child I saw last year?" She looked at John's growth chart, surprised that his body mass index (BMI) was now way over 95% for his age and rising rapidly. He weighed as much as an average 6-year-old. But Dr. Green's concern didn't end with John. His mother, a patient of hers since her teens, had become morbidly obese. Dr. Green felt guilty seeing the two of them, and wondered what she could have done to prevent their obesity. She eventually discovered that there are things physicians can do to make a real difference—for John, his mom, and countless others like them.

Counseling obese patients is not easy, but research shows that patients are much more likely to attempt weight loss after receiving specific advice from their doctor. Surveys find that we doctors have a strong desire to address obesity, but we don't feel confident that our advice is effective. We often feel that we don't have the time, resources or knowledge, and that our efforts are futile. We're tempted to make a quick referral and leave it to someone else; that is if we're lucky enough to have the resources.

Dr. Green is an internist and pediatarician, and Dr. Mortensen is a family physician. Both work at Kaiser Santa Rosa.

Is it worth our effort to take on this worrisome epidemic, one patient at a time? The answer is **yes.** Before we give advice to our patients, however, it's important to understand the multiple factors that are both preventive and causative for obesity. Think of these when you help guide your patients toward healthier habits.

Healthy pregnancies. Health during pregnancy matters—a lot! Women who begin pregnancy overweight and/or gain excessive weight during pregnancy have children with a significantly higher BMI throughout childhood. A 2007 study showed that women who had gestational diabetes with well-controlled blood sugar had offspring with normal BMIs; but if their blood sugar was poorly controlled, their children at ages 5 to 7 were 80% more likely to be overweight or obese.[1]

Breastfeeding. Studies have shown that each month of breastfeeding reduces the chance of obesity by 4%, and that breastfeeding reduces the overall odds of a child becoming overweight by 15–30%.[2]

Family meals. First rule: Eat as a family whenever you can. Children who eat family meals have better nutrition and test scores. Teens who eat five or more meals a week with their family have less depression, drug abuse, early sexual activity and disordered eating. What parent wouldn't want that? Second rule: Turn off the TV. According to one survey, 33% of families always watch TV during dinner, and 27% have it on about half the time.[3] Watching TV while eating a meal contributes to increased energy intake by delaying normal mealtime satiation and reducing satiety signals from previously consumed foods.

Prepare whole foods and make extra for when you don't have time to cook. Likely you will increase the nutritional quality of your meal, feel more satiated and eat fewer calories. Many people think of fiber as helpful in lessening constipation, but it also reduces the risk of heart disease, diabetes and obesity. Foods high in fiber include fruits, vegetables, beans, legumes and whole grains.

Breakfast every day. About 30% of female teens and 40% of all adults skip breakfast, but research shows that mother does know best—a healthy breakfast is the most important meal of the day. Teens who eat breakfast every day have a healthier diet, a lower BMI and are more active than teens who skip breakfast. A 2003 National Health and Nutrition Examination Survey showed that adults who ate cereal every morning had a lower BMI than adults who skipped breakfast or who ate meat and/or eggs for breakfast.[4]

Sleep. Get to bed! Toddlers need 12–14 hours of sleep, youngsters 10–12 hours and teens 8–10 hours. More sleep can lead to up to 25% lower rates of obesity in children. A 2010 study showed that each additional hour of sleep for children 3–5 years old was associated with a 60% reduction in risk of overweight.[5]

Limit fast food. Thirty percent of

children and 40% of adults eat fast food on any given day. Children who eat fast food daily increase their consumption of calories by 187 calories per meal, or 6 pounds of weight per year!

Limit sweetened beverages. These drinks may be one of the most important contributions to obesity. Drinking just one can of soda per day produces an estimated weight gain of 15 pounds per year in adults. Approximately one-half of the population aged 2 and older consumes sweetened beverages on any given day. The highest consumption is among boys 2–19 years old: 70% of them consume sweetened beverages on any given day.

Limit portion sizes. Restaurant and fast-food portions continue to get bigger. An informal survey found that the standard plate size in the restaurant industry grew in the early 1990s, from 10 to 12 inches, and held 25% more food.[6] Plates used in homes have grown as well.

Unplug! Children spend an average of 7 hours daily with media, and children who watch TV 5 hours daily are five times more likely to be overweight than children who are limited to under 2 hours daily. Furthermore, TV viewing from ages 5–15 is strongly predictive of higher adult BMI.

Get moving, preferably outside. Time spent in the outdoors and natural settings can be a paradise for children and therapeutic for adults as well. Exploring a park or a path can help decrease depression and anxiety and improve concentration. Programs that combine diet and exercise counseling have the most effective interventions for adult weight loss. Studies have shown that adults who exercise modestly (30 minutes of walking 5 days per week) increase their lifespan by 1–2 years; and those who exercise more vigorously add 2–4 years to their lives, along with improved quality of life, independence, mental health and less cardiovascular disease.[7]

Limit alcohol. Though studies look at different outcomes for weight and alcohol associations, a general idea comes through: heavy consumption of alcohol, even if done once in a while, is associated with higher BMI. Although research shows that one alcoholic drink per day is associated with a lower BMI, infrequent heavy drinkers were the most overweight.[8]

When we speak to patients or families about their weight, it's important to be careful with our language. We should avoid the word "obese" and of course more derogatory terms. Patients prefer the terms "overweight" or "weight compared to height." When counseling, focus on moving to a "healthy weight" or a "weight that lessens the risk of diabetes and heart problems." Children are often eager to make changes as they learn about things they can do to be healthy. Adults may be eager to make changes for themselves, but often are even more motivated to make changes that support their children.

There are new ways physicians can help children and adults develop and maintain healthy habits to both pre-

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vent and treat overweight and obesity. At Kaiser Permanente, we are using a new tool called the "Get Healthy Action Plan" (GHAP) for obese children 2 years and older. The GHAP allows the physician to work efficiently with a medical assistant to help the family select changes they would like to make from self-determined risk areas. After completing an evidence-based questionnaire, the family leaves the office with 2–3 specific goals they have chosen with their doctor.

Early informal results show that GHAP has made a difference. According to preliminary data, of 54 children seen 5 months or more after the initial visit, 70% had improved their BMI toward the normal curve. (For a video of Dr. Green discussing GHAP with a family, visit YouTube.com and search for "Get Healthy Action Plan." GHAP materials are also available at www.srfmr.org/clinical/patient-education.)

When an adult would like to reduce his or her weight, irrespective of children, tailoring the plan to the adult's needs remains essential. Programs that address emotional awareness, nutrition education, and increasing exercise are most effective. Overcoming Emotional Eating, for example, is a highly successful Kaiser program that is foundational to making behavior changes. A four-session class, which can be taken alone or as a complement to other programs, explores ways to develop life balance, practice stress management, establish healthy boundaries, and break the diet cycle. Patients self-report feeling more confident about their ability to follow a healthier lifestyle, understand cues that were formerly unrecognized, and maintain weight loss.

Kaiser's Lifestyle and Weight Management Program, which runs for 12 weeks, expands on the topics explored in the Overcoming Emotional Eating class. Results from a one-year evaluation showed that 14% of program participants weighed at least 10% less than when they started the program, and 39% weighed at least 5% less.[9] The one-year evaluation also found that 61% of participants said they try to eat healthy foods all or most of the time, compared to 38% of participants when they began the program.

Dr. Green spoke with John's mom one month after starting their Get Healthy Action Plan goals. The mother's voice was filled with pride. John no longer gets chocolate with his milk. Each person in the family has added one new fruit every day.

When his grandmother offered him a juice box, John said, "No, Grandma. Dr. Green said water is better for you." And there was one more bonus: now Mom is inspired to be a better role model and is ready to make her own healthy changes.

Physicians can make a difference, one patient at a time. ◇

Email: cheryl.e.green@kp.org, lynn.m.mortensen@kp.org

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Medical Weight Loss

Jennifer Hubert, DO

Overweight and obesity are complex chronic medical conditions that should be given the same consideration as other chronic diseases. "Overweight" is defined as a body mass index (BMI) of 25–29.9, while "obese" is defined as a BMI of 30 and above. Many comorbid conditions—such as heart disease, type 2 diabetes, hypertension and hyperlipidemia—may be improved or reversed with treatment for obesity and overweight.

Both medical and surgical treatments are available for obesity and overweight. This article focuses on medical treatments, including very low calorie diets (VLCDs) and anorectic medications.

VLCDs

The terms VLCD and PSMF (protein-sparing modified fast) are sometimes used interchangeably, but a VLCD uses liquid meal replacements, whereas a PSMF uses regular food. In the past, VLCDs ranged from 400–800 kcal per day, but now they are commonly set for 800 kcal/day.

Patients with a BMI of 27 and above with comorbid conditions or of 30 and above regardless of comorbid conditions can benefit from a VLCD program. VLCDs can help those who have been unsuccessful on other diets or those that need to lose 30 or more pounds.[1] They can also be used to help the obese lose weight in preparation for surgery, or for patients who cannot or do not want to make food choices.

Dr. Hubert, an internist, is medical director of the MedLite Weight Loss & Laser Center in Santa Rosa.

Patients put on a VLCD should have a complete medical evaluation by a physician trained specifically in the clinical use of VLCDs, such as a bariatrician. VLCD patients need to be closely monitored by the bariatrician or other physician expert. There should be routine lab work and EKG monitoring. A key component of a successful VLCD program is ongoing nutritional and behavioral support and education by trained specialists, such as dieticians and behaviorists.

Women on a VLCD typically lose 3–3.5 pounds per week, and men lose 4–5 pounds per week.[2] The average loss on a VLCD is 2–3 times greater than on a conventional calorie-reducing diet in the same time period.[1] A VLCD can be strenuous on the body and should not be started in patients with a recent myocardial infarction or stroke, or those with pregnancy or a serious illness.

Anorectic Medications

Schedule III and IV anorectic drugs include benzphetamine, diethylpropion, mazindol, phendimetrazine and phentermine. Of these, phentermine is the most widely prescribed. Two Schedule IV anorectics that had been used in combination with phentermine (fenfluramine and dexfenfluramine) were removed from the U.S. market because of heart valve problems. Nonetheless, phentermine was found by the NIH to be useful in weight loss if used for 6–12 months.[3]

Schedule III and IV anorectics have a bad reputation due to their structural similarity to amphetamines and because of inappropriate prescribing. Studies, however, have not shown any tolerance or drug dependence with anorectics. In fact, the Drug Abuse Warning Report of 2006 found that anorectic drugs have one of the lowest drug misuse/abuse rates per 100,000 emergency room visits, even lower than acetaminophen and ibuprofen.[4]

Although most of the published studies of anorectic drugs have run for 12 weeks or less, several studies that have run for longer periods have demonstrated the safety and effectiveness of these medications.[5] With close monitoring and proper starting dose, side effects can be minimized or avoided in most cases.

Non-Approved Treatments

Some weight-loss programs promote the use of human chorionic gonadotropin (HCG), a hormone secreted by the trophoblastic cells of a placenta during pregnancy. However, the use of HCG for weight loss is not approved by the FDA and is not recommended.

In 1954, Dr. Albert Simeons first used HCG for the treatment of obesity in conjunction with a VLCD. He put patients on 500 kcal/day and 125 units of HCG injected 6 days per week for 8 weeks. A few initial studies supported his approach to weight loss, but subsequent studies demonstrated that the HCG part of the diet was ineffective and that the weight loss was solely due to the VLCD portion.[6]

The Future

Several obesity drugs are currently under review by the FDA. In February,

for example, the Endocrinologic and Metabolic Drugs Advisory Committee recommended that the FDA approve Qnexa, which combines the appetite suppressant phentermine with topiramate, an anti-seizure medication that may alter hunger hormones, decrease appetite, and adjust glucose and insulin concentrations. The FDA is scheduled to announce its decision on Qnexa in April.

Contrave, another new drug for treating obesity, was rejected by the FDA last year. The FDA stated that a large-scale study of cardiovascular risk from Contrave would be needed before they could consider approval. Guidelines for the study appear to have been clarified, but approval is uncertain.

The FDA has also accepted a re-application for Lorcaserin, an appetite suppressant. The drug may help to eliminate hunger by stimulating parts of the 5-HT2C serotonin receptors located in the hypothalamus, the control center for metabolism and appetite.

Summary

Obesity and overweight are chronic conditions and should be treated as such. Unfortunately, treatments for obesity typically require a change in the patient's lifestyle and behavior. Without this change, the likelihood that the patient will maintain the weight loss is low.

A multidisciplinary team (bariatrician, primary care physician, dietician, behaviorist) can help patients maintain weight loss. Ongoing support by the patient's primary care physician is one of the most important factors. A little encouragement and reinforcement can go a long way.

VLCDs and anorectic medications can be effective for weight loss, but they should be prescribed by a trained specialist with a comprehensive program. The use of non-FDA approved medications such as HCG is discouraged.

More than a decade has passed since a new weight-loss medication was approved by the FDA and released to the market. Perhaps one of the drugs pending approval could help the two-thirds of Americans suffering from obesity and overweight. ◇

Email: dr.hubert@gmail.com

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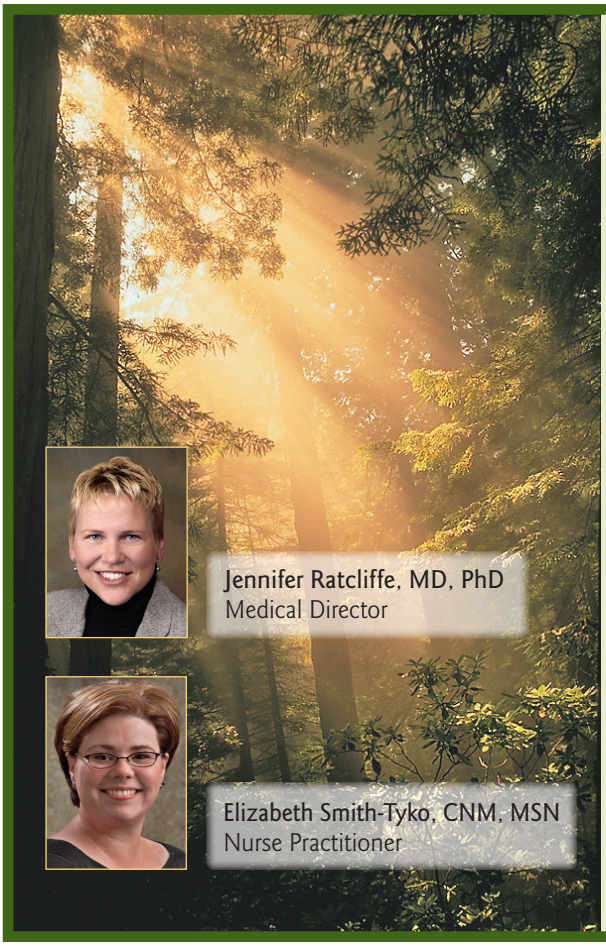

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Families That Eat Together, Stay Together

Mariah Hansen, PsyD

Some of my fondest childhood memories revolve around our family table. As a kid, my eyes would light up at the delicious array of dishes that came from our kitchen. Homemade spaghetti, mac and cheese, Grandma Feld's famous Jello salad, and my mom's decadent desserts made every meal a much-anticipated affair. While these dishes don't represent the healthiest dietary options, the vivid tastes, smells and textures are cemented in my mind.

The meal brought our family together because we all played a role in preparing it. My mom would cook the food, and my brother and I would alternate set-up and clean-up duties. Beyond the ritual and the great food, other important things were happening. Connections were made that held my family together through the stresses of divorce, poverty, adolescent turmoil and other significant family challenges.

Families come to their doctor's office looking for guidance and support around all aspects of health, including family well-being. Because of the influential role physicians play in the lives of their patients, it is important to understand the many different avenues to promoting healthy families. I would like to share one such path: the family meal.

Evidence for the importance of family dinners is not just anecdotal. Over the past 17 years, the National Center on Addiction and Substance Abuse has researched the significance of the family meal. Thousands of parents and teens have been surveyed, resulting in identification of numerous ways in which the family dinner makes a difference.[1] For example, teens who have dinner with their family 5–7 times per week are less likely to smoke, drink or use illegal drugs. Those who have fewer than three meals per week with their family are almost four times likelier to use tobacco, more than twice as likely to use alcohol, and two-and-a-half times likelier to use marijuana.

In 2011, nearly 60% of teens surveyed reported having dinner with their families at least five times a week. However, this number decreases as teens get older. While 55% of 12-year-olds report having dinner with their families, only 26% of 17-year-olds report the same. This disparity is of great concern because the risk of substance abuse is sevenfold for 17-year-olds as compared to 12-year-olds.[2]

Establishing family dinners early and often can provide the perfect opportunity to connect and positively influence your children. Family dinners increase supervised time at home with the family and create more time away from negative peer influences. Meals allow for formal and informal checking-in times in which parents can stay abreast of their child's maturational development and the outside influences impacting thinking and decision-making. Parents might think the last thing a teen wants to do is to connect and talk with adults. When asked, however, teens reported that the best part of dinner was that it was a time to share, talk, catch up and interact with family members. Teens also reported wanting to discuss such issues as peer pressure, dating and substance abuse at dinner with their parents.[1]

It is no secret that adolescence can be emotionally taxing, not only for teens, but also for parents. Research has shown that eating together as a family can serve as a protective factor in areas of emotional well-being. One study found that teens who ate frequently with their families had good self-esteem and were less likely to endorse depressive symptoms and suicidal ideation.[3] In another study, surveyed teens who ate frequently with their families reported less stress and boredom overall.[2] Frequency of shared meals has also been shown to decrease the risk of developing an eating disorder.[4]

Routine family meals also pay dividends in other ways, such as language development and academic achievement. A child's vocabulary is greatly influenced by exposure to conversations, and mealtime conversations have been shown to generate broader vocabulary and more sophisticated word usage than other activities, such as toy play or storybook reading.[5] Mealtimes provide the perfect opportunity for children and parents to engage in animated discussions. Topics that might not otherwise come up organically—such as family history, value lessons, greater world view and sociocultural aware-

Dr. Hansen is a Santa Rosa psychologist.

ness—can be worked into the natural flow of dinner conversations. Academic benefits gained from family meals continue into adolescence. Teens who eat frequent meals with their families are almost twice as likely to receive A's in school when compared to teens who have infrequent meals.[2]

Another benefit of family meals is their effect on childhood obesity. The family meal provides an optimal time to positively influence eating habits through food served and role modeling. Research has made strong connections between children who eat regular family meals and decreased likelihood of obesity, as well as more healthful overall diets.[6] Children who participate in daily family dinners eat more fruits and vegetables and consume less fried food and soda.[7]

The research leaves little doubt regarding the benefits of families eating together. Indeed, one-quarter of teens and one-half of parents surveyed desire more frequent family dinners.[8] So, what gets in the way of sitting down and having a quality meal together? One barrier is packed schedules that include late work hours, long commutes and after-school activities that prevent a family from sharing a mealtime. Another barrier is television. In one survey, 37% of families reported that the TV is usually on during dinner.[8] Other researchers found that having the TV on during dinner was associated with fewer servings of fruits and vegetables.[9]

Frequent family meals are important and beneficial, but the environment created around the table is of equal value. This environment should promote family connectedness and be as free from outside distractions as is possible.

Physicians are in a unique position to encourage family meals for their patients. A good place to start is to help patients identify and explore the barriers to having more frequent family meals. Though this article has focused on dinners, family meals are less about a specific time of day and more about increasing quality time together as a family. Getting creative about mealtimes can be part of the experience. Perhaps everyone in the family can commit to getting up a half-hour earlier and having breakfast together. Improvise with weekend brunches, picnics before or after scheduled activities, occasional meals at or near a parent's workplace, or meals hosted by grandparents or other extended family.

Try to help families establish a manageable starting point, make the commitment, ritualize the process and remain consistent. Once the routine is established, families can adjust aspects to fit their growing and changing needs. Below are some suggestions to get this process off the ground.

Get the whole family involved. Find ways to have the whole family participate in various aspects of the dining process from set-up to clean-up. A simple guideline is that whoever cooks doesn't have to clean up. Cooking duties can be alternated between parents, and a child can be paired to either parent to help cook or clean up. Another fun strategy is to have a night designated for the children to cook. This process can become more and more independent as they grow up.

Have an open seat policy. One impediment to getting teens to share family meals is that teens tend to prioritize time with friends over time with family. Parents can have an open seat policy that welcomes friends to join in during the family mealtime. This way teens don't have to feel divided, and their parents can get better acquainted with their friends.

Plan enticing meals. Meal planning can be another tool to entice adolescents to the table. Feature their favorites on a regular basis, making it hard for them to resist the invitation. Involving teens in shopping and preparation can also be an effective way to keep them invested. These duties can provide them with a sense of responsibility and confidence and may better prepare them for independence down the road.

Create an atmosphere. Dr. Wendy Mogel suggests that the family meal be a time of "moderation, celebration and sanctification."[10] These words act as a guide in creating an atmosphere that promotes health, happiness and appreciation. Parents can model moderate eating through portion size, variety of foods, recommended plate ratios and pacing of the meal. They can celebrate the meal by introducing new flavors, bright colors and intoxicating smells that grab all the senses. Conjuring up recipes from the past can sanctify tradition and culture within the newer generations. The meal can provide a signal to the whole family to slow down and appreciate life a bit more.

Establish dinner etiquette. As a family, set some simple rules to promote connectedness around the table, such as not allowing electronic devices at dinner. Another rule to consider is that everyone has to try everything on their plate, but they do not have to finish any one item. This rule promotes appreciation of the chef, encourages the introduction of new foods, and eliminates much of the power struggle that can occur around getting kids to eat. A third rule is to have a consistent expectation around how and when people can be excused from the table, such as waiting till everyone completes the meal. Finally, meals are a great time to model and teach table manners, such as washing your hands prior to sitting down, eating with your mouth closed, and saying "please" and "thank you."

Keep conversations positive. Conflict, tension and discipline can negate many of the benefits gained from the family dinner. Instead, keep conversations focused on the positive or let them be kid-driven. Meals are a wonderful time to tell stories about family history, or for everyone to tell about the best part of their day.

Cook creatively. You don't have to be a gourmet cook to bring tasty, healthful meals to the table. Many of the books and websites listed below offer a variety of recipes for all levels of cooking expertise, as well as some great ideas on how to get the kids involved in preparation and cooking.

Family meals had a huge impact on my childhood. As an adult, I make

a daily effort to help us all sit down around our family table. New traditions have worked their way into this routine as well. I try to promote healthier eating habits by providing more nutritious options at the table. My son and I have frequented the farmer's market since he was two weeks old to pick out fruits, vegetables and other local fare. Perhaps some of his fond memories from childhood will include roasted butternut squash, sautéed chard and baked sweet potatoes.

I hope the information above provides a useful roadmap for encouraging frequent family meals among your patients. Your encouragement could take the form of one-time advice, goal setting, or putting promotional posters on your office walls. You could even share your own family recipes with your patients. Whatever approach you choose, promoting family meals will help guide your patients and their families toward happier and healthier lives. ◇

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Books on Family Meals

- *The Family Dinner,* by Laurie David
- *The Blessings of a Skinned Knee,* by Wendy Mogel
- *Animal, Vegetable, Miracle,* by Barbara Kingsolver
- *Dinner with Dad,* by Cameron Stracher
- *The Hour that Matters Most,* by Les Parrott
- *The Surprising Power of Family Meals,* by Miriam Weinstein

Useful Websites

- thekidscookmonday.com
- poweroffamilymeals.com
- casafamilyday.org
- thefamilydinnerbook.com
- thefamilydinnerproject.org
- mealsmatter.org
- oldwayspt.org/latino-nutrition

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Ted Epperly, MD

Steve Osborn

Dr. Ted Epperly, the former president of the American Academy of Family Physicians, visited Sonoma County during early March to deliver the keynote address at the annual Excellence in Primary Care conference in Santa Rosa, which was sponsored by the Santa Rosa Family Medicine Residency Leadership Institute. One of the most influential family physicians in the United States, Dr. Epperly helped shape the Affordable Care Act and directs the Family Medicine Residency of Idaho. His new book, Fractured: America's Broken Health Care System and What We Must Do to Heal It, *will be published later this spring.*

The following interview with Dr. Epperly was conducted in Santa Rosa on March 7.

The title of your new book, "Fractured: America's Broken Health Care System and What We Must Do to Heal It," implies that the American health care system is broken. What are the main ways the system is broken?

The system is broken on the front end. We do not have enough primary care physicians, so people do not have timely access to the health care system. Instead of getting seen at an appropriate time for hypertension control or diabetes control, they tend to live sicker. Then they get bad enough that they need to go to an emergency room where the cost could be three to five times more than if they went in a timely way to a physician they had a relationship with. The current health care system is primarily aimed at the back end of taking care of illness and disease instead of preventing people from having those illnesses and diseases in the first place.

Your book title also implies that the system can be fixed. How can it be fixed?

First and foremost there needs to be a much more robust primary care workforce, and there needs to be an alignment of payment that honors what it is to keep people healthy. More people in the system need to be covered with health insurance so that they can gain access and then be driven to the front end of the system. Right now, if you don't have health insurance in this country, you live sicker and you die younger primarily because you avoid going in when you have an early problem, or you might not even know you have hypertension or early diabetes. One of the fixes will be to apply more insurance coverage. The individual mandate will be important for that.

To what extent do you think the Affordable Care Act will fix the problems you have described?

There is a lot of stuff in the Affordable Care Act that will start to fix the system. There are a lot of quality initiatives. Right now, we have no quality strategy in the United States. We get paid fee for service. We get paid on volume. We don't get paid to make sure that outcomes are good. It's like giving a great basketball player the ball and telling him he will get paid every time he shoots. It doesn't matter if he makes a basket or not. We need to start paying for outcomes. We need to start paying for the basket to be made so that we start to get people with diabetes or hypertension under control.

Another thing that the Affordable Care Act does is to give a greater focus on prevention and wellness. We have

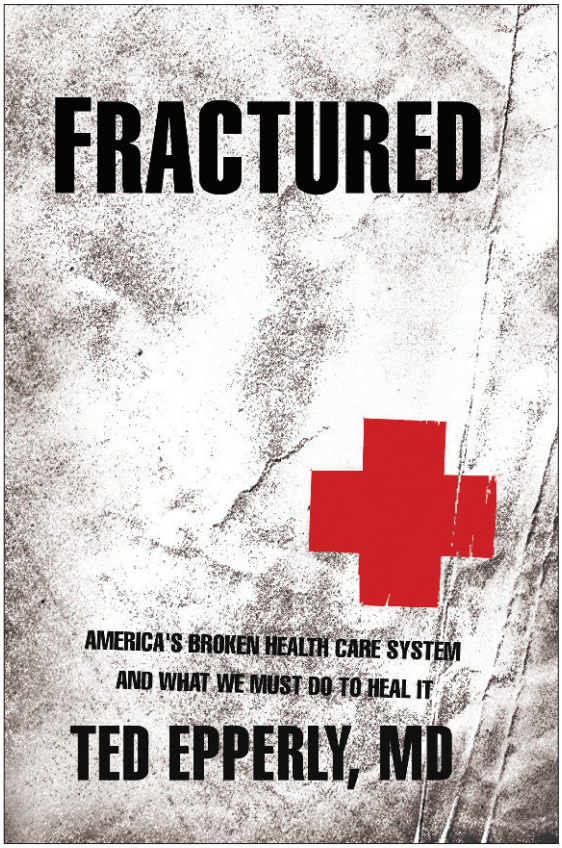
Mr. Osborn edits Sonoma Medicine.

no prevention strategy in the United States. We have no wellness strategies. All our strategies around health care have been reactive. We start to pay for things when people go to the doctor or into the emergency room. If we have strategies to keep people healthier, communities healthier, jobsites healthier, that can be a big deal. And if we incentivize patients to be a part of the solution, that will start to promote a healthier population.

Lastly, back to the workforce issue, there is no policy in the United States at this point about what sort of workforce the nation should produce. We have this total free-for-all system where a lot of medical students are making decisions on what kind of physicians to be based on how much in loans they have to pay back and what income they can make. The payment system is rewarding doctors to go into subspecialties instead of primary care.

Do you think primary care physicians should earn as much as specialists?
Right now the income gap between subspecialists and primary care physicians can be anywhere from two- to five-fold. The data shows that income equilibration is enough to start driving the workforce back into primary care. If you take a look at the workforce balance in other countries—be it France, Switzerland or Canada—it is about 50% in primary care and 50% in subspecialties. In the United States, it is 70% subspecialties, 30% primary care physicians. The more staggering thing is in the last 10–15 years, 90% of the students in medical school are going into subspecialties and only about 10% into primary care. We have this tremendous workforce imbalance that has happened primarily around payment.

If the pay goes up for primary care, will it have to come down for specialties?
Health care costs have to come down overall. We spend $2.6 trillion a year now. About 17% of our gross domestic product is spent on health care, making it the largest sector in the American economy. Our costs are 2-4 times the European average per person. The next closest country is Switzerland, which is paying about 40% less per capita than we are.



That $2.6 trillion has to come down. There needs to be some equilibration of primary care pay and some adjustment of subspecialist pay. I believe there is enough money in the system for everybody to continue to do well. Other places needing decrements in cost are in hospitals, pharmaceutical companies, medical device manufacturers, health insurance companies—all of that needs to be downsized. If our focus improves to be more toward health than disease, we will need fewer of those downstream services.

You worked with President Obama on health care reform. What was your impression of his commitment to reform?
President Obama was incredibly involved with health care reform. I think where the health care message got off track, however, was when he stepped away too early in the public dialogue, and the message got co-opted. People were confused about it and, quite frankly, if a person starts to get angry or confused or scared about something, then the natural default is to say no to change and dig in your heels as opposed to being educated and informed. One reason I wrote my new book was to try to educate the American public better in terms of what is going on with our health care system.

Where do you think the Affordable Care Act is headed? What impact will the pending Supreme Court ruling have?
The Supreme Court will make its ruling on the individual mandate in June. It is only on the individual mandate; it is not on the entire Affordable Care Act. Right now, if it was a totally political decision made by the Supreme Court, it would be 5-4 in favor of abolishing the individual mandate. However, two of the Supreme Court justices in the past have been on record as supporting the provisions of interstate commerce around health insurance. So it is going to be a really close call one way or another, but I think it will be 5-4 in favor of upholding the individual mandate.

In terms of the Affordable Care Act going forward, my sense is that the financial imperative of the system will mandate that the health care system continue to change. Even if a Republican gets installed as president, they still will face a problem with our health care system, and they are going to have to come up with some degree of solution to the problem. One way or another we are going to see something that will be added to the existing Affordable Care Act, or modify it in some way going forward. We cannot just totally walk away from health care—it's too big of a problem. Too many people are uninsured, and too many people

are living sick and dying younger because they cannot get timely access to health care.

As director of a family medicine residency, what do you tell medical students about family medicine? How do you try to recruit them?
Family medicine is about more than money. It is about service. It is about making a difference in somebody's life that is meaningful. Two of the happiest moments I have as a family doctor are when I deliver a baby and when I help somebody die at the end of life with dignity. This specialty is all about working with people in a continuous way over time with the totality of their problems—from mental illness, to hypertension, to diabetes, to domestic violence, to alcoholism, to smoking.

When I talk about a sense of service to a community, of taking care of people over time, of starting to get a handle on the problem of controlling access, of increasing quality at lower cost—that message is resonating with medical students. I think they are becoming more and more aware of what is broken in the health care system.

Do you have any closing thoughts?
In my 32 years of being a family physician, I am very impressed with the physicians I have worked with of all types. The problem we face as a nation is a health care system that tends to value the wrong things. It tends to value disease, injury and illness versus health promotion, wellness and good chronic-disease management. If all of us can come together under the highest ideals of professionalism, to keep patients as the focus of what we are trying to fix here, and get better health care for patients, then we are going to have a better health care system. The focus should not be about retaining pay—it should be about what do we do best to take care of people. If we can act together as professionals to make patients the focus of what we are trying to do, then we will create a better health care system. ◇

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Magazine wins top award

Sonoma Medicine recently won a first-place award in a publications competition sponsored by the Northern California chapters of the Society for Technical Communication, the world's largest organization of technical writers and designers. Beating out dozens of entries from Autodesk, Oracle and other high-tech giants, the magazine earned high praise from the judges, who noted that it "provides a great read in any medical waiting room," and that it has "a professional yet friendly feel."

On the strength of its first-place award, the magazine has been entered into the international STC competition, to be held in Chicago in May.

SCMA members interested in submitting article proposals for the magazine should contact the editor, Steve Osborn, at sosborn@scma.org or 707-525-0101. ◇

The clock is running on implementation of federal health reform. Health care providers and payers are jockeying to position themselves for the impending changes in health care coverage, delivery and reimbursement. Who will survive the demands of the new marketplace? Who will prosper?

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Diabetes: The Musical

Rachel Friedman, MD

I am Sue's pancreas. Once, I was a glistening organ with both endocrine and exocrine functions, proudly situated between the duodenum and the spleen. Bile spilled freely into my common bile duct, mixing with digestive enzymes from the pancreatic duct. A 24/7 multitasker, I competently managed Sue's blood sugars, elegantly responding to external hormonal stimuli with insulin or glucagon. She ate, I facilitated the storage of the energy she took in. The trouble is, she ate and ate and ate.

I am Sue's pancreas. I'm a shriveled, calcified shadow of my former self. <beat> This is my story. (Cue "Pour Some Sugar on Me." Lights rise on exam room.)

Dr. Ellen Green playing Sue's pancreas.

Thus begins the opening scene of *Diabetes: The Musical,* an educational rock opera written, directed by and starring Santa Rosa family doctors. With catchy song lyrics, an engaging plot, and much silliness, this "musical CME" aims to teach healthcare professionals, patients and their families about the diagnosis, management and complications of diabetes in a way that is both fun and informative.

My co-resident Allison Bacon and I wrote *Diabetes: The Musical* last year while completing our family medicine residency in Santa Rosa. We realized that as physicians, a major way we can support patients in preventing and managing common diseases is through education that is delivered in a way that patients understand, remember and apply. Diabetes is certainly one disease where early education, healthy lifestyle changes and patient empowerment are crucial for preventing these profound long-term complications, as well as for preventing disease onset in the first place. The Diabetes Prevention Trial, for example, showed that lifestyle change can be twice as effective as our best medicines at delaying the onset of diabetes in at-risk individuals.[1] We decided that by weaving clinical guidelines into a story sprinkled with likeable characters and familiar tunes, we might create a unique, engaging and effective learning tool that would address both the scientific advances as well as the emotional implications of diagnosing a patient with diabetes.

Diabetes: The Musical emerged from the creative ether during the summer of 2010, when I was chief of the resident medicine service at Sutter Medical Center and Allison was covering the service after hours on night float. I was a former *a cappella* singer with a passion for community outreach and creative learning techniques. I was known among the residents for rewriting the lyrics to a dozen Christmas carols to help myself remember basic management of common hospital diagnoses such as pancreatitis and deep vein thrombosis. Allison was a former college improv troupe member with a belief in the healing properties of laughter, known for her quick wit and propensity for playing pranks on our hospital "falcon," Dr. Rick Flinders.

Somewhere in the cauldron of overnight call, it all came together. Allison cornered me in the R3 Call Room one day after morning rounds, excited and delirious with sleep deprivation.

"I've got it!" she exclaimed.

"What, the pagers?" I asked, confused.

"No, no. I've got it: the Best. Idea. Ever. It's a project for us!" she exclaimed. "You know how you like to rewrite song lyrics to learn medical stuff? And how I like improv and comedy and stuff? What if we went one step further (and here she paused dramatically) . . . and combined our talents to write a medical musical!?"

"Wow Allison, that's a fantastic idea! I'm definitely in. Did you already have

Dr. Friedman, a family physician, is completing an integrative medicine fellowship at the Santa Rosa Family Medicine Residency.

an idea for a topic?"

"Yep. We obviously have to start with one of the most important diseases of our time, so I came to the obvious conclusion . . . "

"Are you thinking . . . ?"

"Yes, Rachel. It has come to this. We must write *Diabetes: The Musical*."

And so, *Diabetes: The Musical* was born.

Over the next few months, Allison and I crafted a basic storyline and wrote the script. For each scene, we picked a popular 1980s song that would be recognizable to a broad audience and rewrote the lyrics to cover patient education or clinical practice concepts. Our first scene, about the diagnosis of type 2 diabetes, is a rewrite of "Sweet Child o' Mine," the classic Guns N' Roses hit.

She's got symptoms and it seems to me
Reminds me of those found in diabetes
Excessive thirst, hunger, blurred vision, fatigue and much peeing …
Now in the office check a random glucose
If it's over 200, suggests diagnosis
Confirmed by a more than 6.5% A1c
Whoa, you've got diabetes
Whoa, you've got diabetes

Our basic plot premise is that in 1987, Sue Cinnamon and her band, Sugar Rush, rocked this world. Overnight, *Sugar* became a household word, changing the four band members' lives forever during their meteoric rise to fame. Now, 25 years later, Sue's life is about to change all over again with another little word: *diabetes*.

Sue's got a lot of learning to do, but she's in good company. One out of 10 Americans currently has diabetes, and that number is growing. The musical follows Sue as she gets diagnosed with diabetes and embarks on the long and sometimes arduous journey of learning how to manage this chronic disease. In addition to her primary care doctor, former band member Dr. Wicked Tiffany, Sue is helped along the way by a quirky cast of characters, including a hippie health educator named Air Trees, an earnest generic drug rep named Lloyd Boyd, and her very own pancreas.

Though peppy and ironic, the musical is packed with useful information for both patients and clinicians, covering the most up-to-date guidelines in the management of type 1, type 2 and gestational diabetes, including evidence-based recommendations around medications, risk factor management and regular screening tests.

DR. WICKED TIFFANY: So … we have been seeing a lot of each other lately, which is awesome. And we do lots of things together too, that are recommended for diabetes. So far we have checked your blood pressure and given you a medicine for that, called an ACE inhibitor.

SUE: I know, right? Where was that guy when Ace Ramsey was stalking our band forever?

DR. WICKED TIFFANY: Um, totally. And then Gee Whiz Ginny decided to date him. Anyway, so now your blood pressure is under 130 systolic and under 80 diastolic.

SUE: Also each time we get to use the monofilament and check my feet to make sure I haven't lost the feeling in my feet. (Pulls out personal, crystal-studded monofilament).

DR. WICKED TIFFANY: That thing is a work of art. Then we do lots of blood tests. We check your hemoglobin A1c every three months because it's still higher than a kite, and your cholesterol and urine protein every year. Your LDL cholesterol is under 100 now because you are on a statin medicine.

SUE: And I saw the Eye Guy. Once a year now I get to do that.

DR. WICKED TIFFANY: Right, and you saw Air Trees and you quit smoking, which is the most totally awesome thing of any of this.

SUE (sarcastic): Um, sure, it was a blissful experience.

After a harrowing few months trying to finalize the script while still beset by the unsustainable work hours and circadian arrhythmia that is medical residency, we recruited our first cast from among our equally busy colleagues at the residency. In April 2011, with just a few practices under our belts, we turned the Vista Health Center conference room into a makeshift stage and put on a rousing (if not fully polished) debut performance for the rest of our resident and faculty colleagues. As our belted-out lyrics wafted through the clinic, word spread of our performance, and several medical assistants and other staff stopped by to see the doctors act and sing about diabetes.

The second act opens with a hospital scene, where Sue is being treated for cellulitis and runs into another former bandmate, Gee Whiz Ginny, whose son Max has just received a new diagnosis of type 1 diabetes. Max's doctor explains why Max has been hospitalized, using the song "D-K-A," sung to the tune of "YMCA."

Young man, if your glucose is high,
And you drink lots, but mucous membranes are dry,
Better get yourself to the nearest ED
Before you get breath that's fruity

Young man, if your bicarb is low,
Better watch out, to ICU you must go,
Acidosis, with an anion gap,
And serum ketones make it a fact,

(chorus)
You've got an illness we
Call D-K-A
A metabolic state
Called D-K-A,
Nausea and fast breathing,
Ketones cause vomiting,
Fluids lost and you can't compensate

Following that first performance, we were invited to perform for the 350 doctors, nurses, health educators and students attending the Sonoma County Latino Health Forum last October. By then, Allison and I had both graduated from the residency, and Allison was working in Santa Fe, New Mexico. We were able to bring her back for the performance, but we realized that if we wanted to continue sharing the musical

with more and more people, we were either going to have to quit our day jobs, find a traveling troupe of real actors or . . . turn our live performance into a video.

In December 2011, we raised over $3,000 via a Kickstarter.com campaign to fund the filming and editing of the video version of *Diabetes: The Musical.* Each scene became a self-contained chapter, or episode, and we hope to permanently house these "webisodes" on a free website in the near future, where anyone with Internet access will be able to watch the musical and access related content.

Cast members during the filming of "Diabetes: The Musical."

Are we onto something with *Diabetes: The Musical*? Could this herald a new era of musical health education? One recent study of various types of health education in patients with diabetes found that those receiving "interactive" education, compared to conventional lectures, were more likely to achieve control of their HbA1c, blood pressure and lipids.[2]

Teachers have long used music as a mnemonic device, recognizing its power to augment recollection of facts. Likewise, a growing body of literature has demonstrated positive effects of music therapy in restoring and maintaining cognitive abilities in people with dementia, multiple sclerosis, strokes and other conditions that affect memory and cognitive abilities.[3]

But what exactly makes music such a useful learning tool? Although there is popular belief in the power of musical mnemonics, studies have failed to nail down a definite mechanism. Some have pointed out the ability of musical phrasing and rhythms to "chunk" information into manageable units.[4] This structure may assist in learning and retrieving the text or lyrics.[5] Others studies have tried to assess the effect of familiar melodies to augment learning and memory for unconnected texts.[6] But as Dr. Matthew Schulkind has observed, the studies have not all come out in favor of music as a "special" learning aid. "The special power of music as a mnemonic device," he writes, "may in fact be related almost exclusively to the known fact that repetition is crucial for learning anything, and a song is more likely to get involuntarily repeated in your head than a lecture or written text."[7]

This phenomenon of songs getting stuck in one's head is popularly known as an "earworm," but the scientific term is "involuntary musical imagery." If earworming is the key to music's ability to facilitate learning, *Diabetes: The Musical* is certainly a winner. Many of us in the cast have found ourselves unable to stop replaying the catchy phrases from these hit songs turned into medical guidelines.

Our next live performance will be on the main stage at the annual scientific assembly of the California Academy of Family Physicians in April 2012. We have a Facebook page, *Diabetes: The Musical,* where interested folks can find out more information and get updates on our progress. And we would love to grow our fledgling "musical CME" company; let us know if you would like to get in on the ground floor of our next medical musical endeavor—*COPD: The Spaghetti Western.*

Allison and I have a shared long-term vision of creating a medical educational learning collaborative to support others in pursuing ideas and projects similar to *Diabetes: The Musical.* As chronic diseases continue to incur an enormous financial and emotional burden on the health of our patients in primary care practices, we hope to find innovative strategies such as these to effectively educate and empower patients and clinicians. For providers, we hope that *Diabetes: The Musical* offers a fun and catchy way to learn and remember new guidelines while also getting a patient-centered view of the diabetic experience. For patients, we hope that our webisodes will offer a free and accessible understanding of the complex concepts inherent in managing and living with diabetes. And finally, we hope that for everyone, *Diabetes: The Musical* offers a whopping dose of laughter, which everyone knows is the best medicine of all. ◇

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Financial Aspects of an IDS Affiliation

Dieter Thurow, CPA/PFS, MBA

Physicians still in private practice are currently faced with what's arguably the biggest decision of their career: whether, and when, to give up their independence and affiliate with an integrated delivery system (IDS). This decision is not only complex, but also must be made in an uncertain environment.

Implementation of the Affordable Care Act has already begun. Regardless of the legal or political future of that legislation, most observers agree that fundamental changes in the healthcare delivery system will take place over the next 3-5 years. Many of those observers believe the independent physician and the fee-for-service compensation model will no longer be viable.

A basic question facing independent physicians is what will happen to their compensation in the future. Although there are plenty of theories as to how medical care should be delivered, and how physicians would be compensated within those systems, many local doctors have questions as to what the reality will look like. Specifically, they want to know how the changes will affect individual physicians, when the changes will come to Sonoma County, and how physicians can prepare for them.

To complicate matters, just about every independent physician is in a different situation. The answers to the questions above, and the approaches to finding them, vary according to the physician's age, specialty and type of practice, among other factors.

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The three main integrated delivery systems in Sonoma County are Kaiser Permanente, Sutter Health and St. Joseph Health System, all of which have affiliated medical practice foundations and/or medical groups (e.g. The Permanente Medical Group, Sutter Medical Group of the Redwoods, Annadel Medical Group). All three are competing for an increased share of paying patients and are actively recruiting physicians.

Kaiser has the most well-established IDS in Sonoma County and continues to attract physicians by offering employment through The Permanente Medical Group. (Because the Kaiser IDS is so well known, the remainder of this article focuses on the more recent IDS efforts by St. Joseph and Sutter.)

St. Joseph is using at least two approaches for recruiting physicians. The first is to expand its base of primary care and specialty physicians by investing in the foundation model and partnering with physicians in Annadel Medical Group. The second is to collaborate with independent physicians through joint ventures or other models of shared decision-making.

With the construction of their new hospital in Santa Rosa, Sutter is accelerating its efforts to attract physicians. They are prepared to commit substantial amounts of capital to acquiring the practices of local primary care physicians and specialists.

One of the financial incentives offered by Sutter and St. Joseph is to guarantee the physician's compensation for a certain period of time. Annual income is generally somewhat higher than the physician's average earnings over the last couple of years. After the initial guarantee period, compensation may be based on a variety of factors, such as "production" or other incentives that promote alignment with IDS goals.

Both Sutter and St. Joseph will purchase the "hard assets" of a practice at fair market value. There is generally no payment for medical records, "good will" or future earnings because the physician will continue to benefit from that practice through a salary guarantee or a production-based compensation model. For ancillary services such as imaging, lab and outpatient surgery, however, the IDS may pay for several years' worth of future earnings because the revenue from all ancillary services remains with the IDS. For specialists who offer these services, these payments may be substantial.

One advantage of affiliating with an IDS and changing employers is that existing 401(k) accounts can be rolled over into self-directed IRAs that may offer more diverse investment opportunities. Another positive aspect is that employee benefits are often paid by the IDS. Savings on health care and malpractice insurance premiums, for example, can be significant.

There is a real benefit in preparing for the upcoming challenges in health care before making any decisions. Thinking about the possible scenarios and evaluating available opportunities—all while being fully committed to a medical practice—can be a daunting task. Starting on a Strategic Business Plan brings the necessary discipline

and focus to reach the best decisions possible.

Larger groups face the biggest challenge right up front, i.e., getting all the partners to agree whether some type of affiliation is even necessary or desirable. Dealing with this resistance, agreeing on common objectives, and getting at least a majority of partners on the same page can be time-consuming and frustrating. The earlier these differences are addressed and resolved, the better. Doctors who have gone through the process have found that it is most productive to set up a disciplined schedule for meetings. Also, each partner should be assigned a specific component of the planning process to investigate and report back to the group.

To get a handle on the impact of coming changes, the first step in a Strategic Business Plan should be a risk analysis. One major question is where patients will be coming from. Specialists will need to evaluate the potential vulnerability of their practice if some of their major referral sources affiliate with an IDS.

A second step in the Strategic Business Plan is to look analytically at the competition. A competing specialist, for example, could also be considering an affiliation with the same IDS. Such an analysis is crucial in assessing one's own negotiating strengths and weaknesses.

Valuing the practice is another important step in looking at one's options objectively. For most physicians, the value of their assets, such as office or medical equipment, may not be all that meaningful. However, for specialists who own outpatient surgery centers or other ancillary services, the value of their assets could be quite significant. Using outside consultants to assist in valuing these assets could be beneficial for specialists.

A final consideration is real estate. An IDS may lease space in physician-owned properties as long as the rates and terms are at fair market value. Some leases may be long-term, but others may expire after only a few years. These variables need to be considered as well.

To reach an informed and conclusive decision in dealing with impending changes, physicians should develop a Strategic Business Plan as soon as possible. Those who are fully committed to planning their professional future will be able to deal with the inevitable challenges more effectively and achieve a better outcome. ◇

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Making Time for Lucy

Colleen Foy Sterling, MD

A skylight lets plenty of natural light into the office of psychiatrist Dr. Jennifer Beck at St. Joseph Behavioral Health Services in Santa Rosa. Some of her patients are severely depressed, and perhaps the light gives them a ray of hope. It seems fitting that the skylight makes her office seem almost out-of-doors: she is an outdoors-woman, and being outdoors is how she keeps balance in her life.

Beck was born and raised in Ohio, but her family moved to Northern California when she was seven. She is now a busy psychiatrist. She has an office in Petaluma, where she focuses on geriatric psychiatry, neurodegenerative cognitive disorders, and late-life depression and anxiety. She also has another private practice at the Well-Mind Center in Santa Rosa, where she is the first Sonoma County psychiatrist to offer transcranial magnetic stimulation (TMS), a new FDA-approved treatment for depression that uses a high-powered magnet to non-invasively stimulate the prefrontal cortex. As a consulting psychiatrist for St. Joseph Behavioral Health Services, she is also part of an award-winning team that forms a crucial safety net for area residents who struggle with acute mental health diagnoses.

Dr. Foy Sterling, a Santa Rosa family physician, serves on the SCMA Editorial Board.

Beck includes a variety of treatment recommendations in her repertoire. In addition to medication and TMS therapy, she is a promoter of healthy diet and exercise and knows how important nature and the outdoors are to mental well-being. Like many Sonoma County physicians, Beck practices what she preaches. As dedicated as she is to her busy career and her deserving patients, there is someone to whom she is so committed that she ventures out to Guerneville Road 4-5 mornings per week, at around 6 a.m. That special someone is her horse, Lucy.

Beck enjoys both trail-riding and dressage, which is often called "horse ballet." Dressage riders use progressive training to bring out the best in the horse's natural abilities. During competition, which ranges from amateur to world-class, the horse performs to its peak athletic abilities with minimal guidance from its rider.

Recently, Beck took time out of her busy schedule to answer my questions about her relationship with Lucy.

How does your activity and relationship with your horse Lucy help you stay balanced and well?

Lucy and I had a rocky relationship at first. She is very opinionated, and when I first got her, she literally walked all over me. I have since learned to be in charge, firmly yet kindly, which not only helps in my relationship with Lucy, but also personally and professionally. At this point we have settled on a quiet agreement that we will work together as a team. This was the first of so many things that Lucy has taught me: assertiveness training.

I read an article once about having the horse's body and legs just be an extension of your own, like a centaur. The goal is to merge and become one. That takes a lot of concentration, effort and communication. The communication is, of course, mostly nonverbal. I think I like the nonverbal part the best. You might think that odd coming from a psychiatrist, but I talk so much during the day, it's nice to be with someone and not talk, but still have a close relationship.

Lucy and I work together to accomplish things. It might not seem like an effort, just sitting on the horse, but it

is actually work to get her to "collect" (pull her body together and drive from the rear), ride in complicated patterns and change gaits. All this without words! What a beauty that is!

I think being with Lucy keeps me healthy and well for several reasons: I am outdoors; I have friends that I ride with; it is good exercise; and my mind is free of work-related issues.

Would you even call riding a hobby? Would you call it something else?
I'm not sure *hobby* is an appropriate word. Because riding is hard work, and because it is so time-consuming, I think it has to fit in the category of "life passion." I see riding as sort of a meditation. I have to clear my mind of all other things and focus on the relationship and the goals at hand.

When did you start to ride?
I actually didn't start to ride until I was almost 40. I loved horses as a girl and visited the horses down the road and mucked out stalls occasionally, but I was not able to ride. In 2003, I took a class through Santa Rosa Junior College at Cloverleaf Ranch, here in Santa Rosa. Initially, I was terrified. I trembled the whole time I was grooming and saddling the horse. I don't think I shook once I was on the horse, but I sure was terrified. That class was extremely helpful. In fact, I took it twice!

I got Lucy in 2006. Lucy was 15 and was retiring from a sport called "reining," in which the horses gallop at full speed, do patterns and slide to a stop. This can be very hard on their hocks, so it was time for her to move to something else. She has been an excellent teacher in many ways. I had to catch up with her, as she is a highly trained horse and I was a "green" rider.

Do you share your interest in horses with your patients?
I believe that all my patients and their family members know that I ride. I wear a necklace that is an artistic horse head, and my office has a large metal horse wall sculpture that I got in Mexico a few years ago. I do talk "horse" with patients occasionally. Maybe tell a few funny stories or share Lucy's "assertiveness training" techniques if that's relevant.

Do you have a scheduled time that you go riding? Or do you ride more spontaneously, when you are in a mood to do so?
This is a passion for me, so I do it as much as possible. Also, I feel that I have made a commitment to Lucy to ride her and get her out. She is a very athletic horse and needs to be ridden. I ride at least 4–5 days per week. Because of my schedule, I am usually out there early—as early as 6 or 6:30 a.m. I ride for a couple hours and head out to work. I am always in the mood to ride! On the weekends, we try to get off the ranch and ride in the vineyards or at one of the regional or state parks.

Have you ever worked with a horse program that helps children or adults with mental health problems?
I volunteered at Giant Steps, a therapeutic riding program in Petaluma, for a few years. I worked with children with autism, OCD, Down's syndrome, and other emotional and physical issues. It was really fun to see the kids grow and change. A boy with autism told me a joke that was really funny. Humor is often difficult for people with autism, so it was nice to see him stretch out of his comfort zone. I think horses and animals in general give us permission to do that.

Do you ride with other people?
I have several friends that I ride with. A couple of them I met in the JC class and the others I met at the ranch where Lucy is boarded. Most of them were already riding or had their own horses. We do a lot: dressage in the arena and at shows; trail rides in the vineyards or parks; and camping at Pt. Reyes. We have also become friends and do non-horsey stuff too.

If you don't have a chance to ride, how do you feel? What do you miss the most about it?
I start to get antsy and begin to think too much if I have not ridden. Riding is centering and calming for me. I also just miss seeing Lucy and being with her. Sometimes I go out to the ranch and get her out of her pasture and just let her graze and don't ride at all. I just stand near her, watch her eat—a really comforting sound—and let her be. That's probably the most relaxing thing I do.

How does your love of horses intertwine with your career choice and your vocation at this time in your life?
I think riding really helps me to be more present when I am with patients. In fact, more present in all aspects of my life. I think I have a different level of understanding on the nonverbal level. If I have to be a good listener and communicator with my horse, then I will hopefully be even better with people. ◇

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Questioning the Obesity Paradigm

Deborah Donlon, MD

Why We Get Fat: And What to Do About It, by Gary Taubes, 272 pages, Knopf.

As physicians, we think we know what causes obesity. Eating too much. Exercising too little. Sedentary jobs and leisure activities. Soda, chips, channel surfing and junk-food advertising. We counsel our patients to eat less and move more. I confess I am skeptical when an obese patient tells me she "eats tiny portions" and "exercises all the time." Based on what I learned in medical school about calories consumed versus calories expended, this just can't be true.

Or can it? In his book, *Why We Get Fat: And What to Do About It,* Gary Taubes argues against the prevailing wisdom about what causes people to gain weight. Over 10 years ago, best-selling author Taubes found that he continued to gain weight despite exercising regularly and restricting both caloric intake and fat consumption. As a self-identified carnivore, he started himself on an Atkins-like diet consisting of animal protein, healthy fats and vegetables—and lost 20 pounds in six weeks. He has maintained his weight loss by staying on the diet, and has spent the past decade researching the connection between specific foods we eat and their effect on our weight. (He is also the author of *Good Calories, Bad Calories,* a highly technical tome less accessible to the lay public than his current book.)

Dr. Donlon, a Santa Rosa family physician, chairs the SCMA Editorial Board.

In *Why We Get Fat,* Taubes challenges widely held beliefs. For example, we tend to think that obesity is caused by affluence and abundance, or having "too much of a good thing." We think that wealth, including the ability to buy machines to do work for us and transport us, is what is making us fat. Taubes turns this belief around by highlighting the historical connection between obesity and poverty. The Pima Indians became increasingly obese during a period of economic decline and famine. The poorest Americans during the Great Depression were those most likely to be obese. Today, people who live in poverty and are employed in physically demanding jobs have a high rate of obesity, as well as malnutrition. Under Taubes' examination, the paradigm connecting obesity to too much food and too little activity begins to weaken.

Taubes follows his history lessons with two fairly discouraging chapters titled "The elusive benefits of undereating" and "The elusive benefits of exercise." Prior to the 1970s, he observes, low-calorie diets were referred to as "semi-starvation diets," the idea being that people would have great difficulty following such a regimen for a couple of months, let alone permanently. Well-controlled studies, according to Taubes, have failed to show a connection between calorie restriction and sustained weight loss. And vigorous exercise, while having numerous health benefits, leads to hunger and increased caloric intake. This fact limits the utility of exercise as a weight-loss strategy. Nonetheless, despite the lack of evidence for calorie restriction and exercise, the multibillion-dollar diet industry continues to promote these behavior changes for weight loss—and profits from our failures.

For Taubes, "why we get fat" turns out to be a complex interplay between genetics, diet and lipid metabolism. Those looking for a crash course in thermodynamics will be pleased to find one in his book. Basically, the more fat cells we have in our bodies, the more those fat cells drive us to eat, and the more energy they rob from other cellular functions in the body. "What to do about it" requires identifying a villain that we should avoid in our diets. Taubes' villain is the carbohydrate, which drives insulin secretion, which drives energy storage in fat cells. According to Taubes, the more carbohydrates we consume, the more we crave, and the fatter we become. The same carbohydrates zap our energy and leave us unmotivated to exercise. So, our fat cells from excess carbohydrate intake turn us into couch potatoes, rather than the other way around. The last chapter of Taubes' book offers a nutritional program in which carbohydrates are essentially eliminated in favor of animal protein, vegetables and fats.

In the arena of weight-loss research, every argument has a counter-argument. One of those taking a contrary view to Taubes is local physician Dr. John McDougall, whose new book *The Starch Solution* will be published in May. According to McDougall, animal

products are what should be limited in the American diet. He recommends a low-fat, vegan diet that includes liberal quantities of starches such as rice, beans and potatoes.

Let's return to our obese patients, who turn to us for advice on how to become healthier and lose weight. Do we have an answer? If our patient is to follow Taubes' regimen, a short list of what she must give up includes soda, chocolate, alcohol, milk, bread, potatoes, rice, all fruits, and even some starchy vegetables like carrots. What remains are eggs, meat, salads, most vegetables, oils and fats.

There are two practical problems here. One, carbohydrates are ubiquitous in the typical American diet. They are everywhere we turn, from our refrigerators to our cupboards to grocery stores and restaurants. Second, carbohydrates are cheap, so they are what most Americans can afford to feed their families. Eating only foods on Taubes' approved list would be cost-prohibitive for most of our patients.

Why We Get Fat is well researched, well written and convincing. The diet therein may work well for people of means and willpower. For the rest of us, and our patients, the best advice we can follow is to become more mindful and moderate in our dietary habits. Some examples: try to sit down for a family meal; reduce portion size by reducing the size of the plate; put the fork down between bites; turn off the television; drink water instead of soda; limit fast food and processed food; serve as many vegetables as your family can afford; enjoy active time outside.

The preceding may sound like a long list, but patients tell us when they are ready to make a change, and which goals they think they can accomplish. With our help, they can make strides into understanding how they have become obese, as well as their own paths for "what to do about it." ◇

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How Local Is Our Food?

Jeff Sugarman, MD

Obesity is epidemic in the United States and is a major cause of deaths attributable to heart disease, diabetes and cancer. The need for programs to address this epidemic is great, but creating these programs will be a huge challenge. Unfortunately, economics and politics influence what we eat far more than we realize.

The Obama administration recently announced changes to government-subsidized school meals affecting the daily diet of more than 32 million children. What surprised me was how many stakeholders tried to influence the debate and the subsequent final rules. The National Potato Council, for example, opposed attempts to limit the servings of potatoes (presumably in chips and fries). Lawmakers from potato-growing states opposed earlier versions of the lunch program because they would have cut the amount of potatoes served. The American Frozen Food Institute was concerned about guidelines restricting sodium levels. There was even a fight over how much tomato paste would have to be put on a piece of pizza for it to count as a vegetable.

Dr. Sugarman, a Santa Rosa dermatologist, is president of SCMA.

Even as the obesity epidemic has increased during the past few decades, we have been told by nutrition experts and the American Heart Association to eat a low-fat diet. While I don't doubt that diets high in saturated fat contribute to increased LDL cholesterol and subsequent coronary artery and other vascular diseases, I have often wondered if the replacement of fat calories in our diets by carbohydrate calories has influenced the obesity epidemic. As Gary Taubes argues in *Good Calories, Bad Calories,* the addition of high-fructose corn syrup to just about every processed food we consume exacerbates the obesity problem not only by increasing the caloric content of foods, but also by efficiently stimulating insulin production.

Why is high-fructose corn syrup so ubiquitous? Farm subsidies and commodity pricing policies keep corn prices artificially low, allowing food manufacturers to save a few pennies on each item by sweetening processed food with high-fructose corn syrup rather than table sugar.

Physicians and policy experts have attempted to combat the epidemic by encouraging regular exercise for both children and adults. Sonoma Health Action, for example, started the iWALK program in 2009 to address this critical issue. Participants are encouraged to walk at least 30 minutes per day, five days a week. Such programs are a crucial component of a healthy lifestyle.

While I agree wholeheartedly with initiatives to increase exercise, when it comes to weight loss and weight control, I believe that diet trumps exercise. I felt great after my 30-minute workout on the treadmill before work the other day. The computer on the treadmill, however, told me that for all my efforts I had burned only 380 calories. Next stop, the coffee cart (I was kind of hungry). The muffin that I devoured in 90 seconds gave me back those 380 calories, and probably more.

The obesity epidemic is surely a Herculean problem. Many people do not have access to safe, nutritious and affordable food. Ironically, despite the pent-up demand for healthy food, many small independent farmers cannot make a living.

Our responsibility as physicians is to educate our patients about healthy food, but we also need the political will to curb subsidies that make fast food artificially cheap. Change will require sustained public policy initiatives that promote consumption of healthy whole foods through increased access, education, awareness and affordability. Change will also require the personal will of every one of us to make the right choices: consuming healthier foods, consuming smaller portions and increasing fitness through both aerobic exercise and resistance training. ◇

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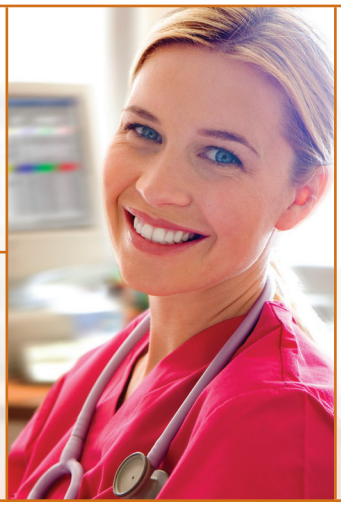

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